Smiles by Hanna
1355 S. Higley
Ste 119
Gilbert, AZ 85296

(480)279-3700

www.SmilesByHanna.com

smilesbyhanna@gmail.com

Smiles by Hanna
Patient Acknowledgement of receipt Notice of Privacy Practices

Our Promise!

It is our desire to communicate to you that we are taking the Federal (HIPPA- Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

The most significant variable that has motivated the Federal goverment to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The goverment has appropriately sought to standarize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writting the policies and procedures we use to ensure the protection of your health information everywhere it is used.

Patient Name:* _____ * _____ _____ _____

Last First MI Preferred Name

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents of the Smiles by Hanna Privacy Policy.

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Smiles by Hanna Financial Policy

In order to enhance communication and promote understanding regarding this offices financial policies, please read through the following information. After reading, please provide your signature at the bottom indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please ask to speak with the office manager. Thank You.

Insurance

We are happy to bill both primary and secondary insurances as a courtesy for our patients. It must be understood that each patient is ultimately responsible for the cost of services rendered regardless of insurance coverage. All insurance policies are a contract between the patient and the insurance company and we cannot be held responsbile for payment decisions made by any insurance company. We will do our best to estimate accurate insurance coverage and patient portion due; however, if the insurance company does not pay the full amount anticipated, the patient is responsible for the difference. Oral Cancer Screening is $50 and is recommended once a year and services will be billed if applicable.

Fillings

Dr. Hanna Mansoor places resin-composite (tooth-colored) fillings when necessary. It must be understood that some insurance companies only pay for amalgam (silver) fillings and the difference is the patients responsibility.

Payment

* ☐ The patient portion due for services rendered is expected at the time of service unless previous arrangements have been made with the office manager. It must be understood that for all appointed procedures, Smiles By Hanna will collect the full cost of treatment to reserve an appointment with Dr. Hanna Mansoor. We accept Cash, Visa, Mastercard, American Express and CareCredit. Payment would be expected immediatly upon receiving the statement. After 30 days of non payment a late fee of $25 will be added to the patients account. After 60 days a finance charge of 3% not to exceed 18% on an annual basis, will be added to your account and it will be turned over to our collections department. The patient is responsible for all finance charges, collection costs, attorneys fees and any other costs that may be incurred to enforce collection of any amount outstanding. By checking this box I acknowledge that I have read this statment and agree to the contents.

Financing

We have several financing options which will be review by the treatment coordinator. If you have an interest in these options, please consult with the office manager prior to the date of scheduled treatment.

No Show/Missed Appointments:

* ☐ We request notice to cancel or reschedule an appointment at least 48 business hours in advance. If appropriate notice is not given, a charge of at least $50 may be assessed to the patients account. By checking this box, I acknowledge that I have read this statement and agree to the contents.

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Refunds for Unfinished Treatment

* ☐ If a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager. By checking this box, I acknowledge that I have read this statement and agree to the contents.

Credits on an Account

If an insurance company pays more than anticipated, creating a credit for the patient, we are happy to either refund the patient or leave the credit on the account to be applied toward future treatment.

* ☐ By Checking this box, I acknowledge that I have read the Financial Policy and Privacy Practices of Smiles by Hanna. I agree and understand the contents contained therein.

Record Release

* ☐ Patients are allowed to get copies of their x-rays after paying the usual & customary fees. X-rays are transferable to other dental offices after payment is rendered.

Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Response Date: _____